REQUEST TO ADD COMMERCIAL INSURANCE INFORMATION FOR HEALTH PLAN MEMBERS

Michigan Department of Community Health

INSTRUCTIONS:

- Complete this form and send to:
  REVENUE AND REIMBURSEMENT DIVISION
  BUREAU OF FISCAL REVIEW AND REIMBURSEMENT
  MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
  PO BOX 30435
  LANSING MI 48909
- FAX: **(517) 346-9817**
- EMAIL: **TPL_Health@Michigan.Gov**
- If you have questions or comments, please call **(517) 335-9726**.
- This form and other information are also available through the internet at:
  www.michigan.gov/mdch/1,1607,7-132-2945_5100-20412--,00.html

Health Plan Name	Date
Contact Person Name	Contact Person's Phone Number
Medicaid Beneficiary Name	Medicaid I.D. Number
Commercial Insurance Name	Commercial Insurance Phone Number
Commercial Insurance COMPLETE ADDRESS (No. & Street, Suite No., City, State, ZIP Code)	
Type of Coverage: (use an "X") ☐ **Traditional** ☐ **Managed Care** (Preferred Provider Organization, Health Maintenance Organization, Point of Service)	
Name of Pharmacy Benefit Manager (if utilized)	Phone Number (if available)
Policyholder Name	
Policyholder Social Security Number / Contract Number	
Group Number	Effective Date of Commercial Coverage
Employer Name (if known)	
Additional Comments *(include covered dependents and their Medicaid ID Number)*:	
Has this information been verified with the Commercial Carrier? ☐ **YES** ☐ **NO**	

AUTHORITY:	Title XIX of the Social Security Act
COMPLETION:	Is VOLUNTARY, but is required if Medical Assistance program payment is desired.

The Department of Community Health is an equal opportunity employer, services, and programs provider.